

Dr. J. Williams

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000912

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 61

1. PLACE OF DEATH
a. COUNTY **GREENE**
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **SPRINGFIELD** Inside Limits Yes No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **FOSTER NURSING HOME** Length of stay in 1b **3 1/2 YRS.**

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **MISSOURI** b. COUNTY **GREENE**
c. CITY OR TOWN **SPRINGFIELD** 0396 Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) **1111 MT. VERNON** Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last **MARY E. ALLEN**
4. DATE OF DEATH Month Day Year **JAN. 16 1959**

5. SEX **FEMALE** 6. COLOR OR RACE **WHITE** 7. MARRIED NEVER MARRIED WIDOWED DIVORCED
8. DATE OF BIRTH **MARCH 22 1863** 9. AGE (In years last birthday) **95** IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **HOME** 10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) **ILLINOIS** 12. CITIZEN OF WHAT COUNTRY? **USA**

13a. FATHER'S NAME **JAMES DAILY** 13b. MOTHER'S MAIDEN NAME **MARTHA HEATHMAN** 14. NAME OF HUSBAND OR WIFE **CHARLES E. ALLEN (DEC.)**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **NO** 16. SOCIAL SECURITY NO. **NO** 17. INFORMANT Address **MRS. OLIVE WESTMORELAND, SPFLD, MO.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Jaundice
DUE TO (b) _____
DUE TO (c) N
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Multiple deubita ulcer 794X
19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1-8-56 to Jan 16 59 and last saw her ^{him} alive on 1-10-59
Death occurred at 1:15 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Johnnie J. M.D. 22b. ADDRESS Springfield 22c. DATE SIGNED 1/16/59

23a. BURIAL, CREMATION, REMOVAL (Specify) **REMOVAL** 23b. DATE **1/19/59** 23c. NAME OF CEMETERY OR CREMATORY **COUNCIL HILL** 23d. LOCATION (City, town, or county) (State) **BELLE PLAINE, KAN.**

24. FUNERAL DIRECTOR ADDRESS **H.H. LOHMEYER SPRINGFIELD, MO.** 25. DATE RECD. BY LOCAL REG. 1-19-59 26. REGISTRAR'S SIGNATURE Offie S. Mellon

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300 4
1-57

FILED JAN 26 1959

FEB 24 1959

VS OCT 8 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Student Embalmer No. working under my personal supervision.

Student Signature of Student Embalmer

Signed Gene C. Hunter

Licensed Embalmer No. 11739

P. O. Address 512

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license). If embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.